TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
HUNT REGIONAL MEDICAL CENTER

Respondent Name
OLD REPUBLIC INSURANCE COMPANY

MFDR Tracking Number
M4-17-1031-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
December 12, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Texas Administrative Code 124.1a3 Per Texas Dept. of Insurance/Workers' Compensation: a claim submitted 'must' be considered the First Report of Injury if no Employer's First Report of Injury has been filed."

Amount in Dispute: $13,673.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier did not have a claim file for this claimant and this date of injury. The carrier denies receiving a timely submitted medical bill from the provider."

Response Submitted by: Flahive, Ogden & Latson, Attorneys At Law, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
December 28, 2015	Outpatient Hospital Services	$13,673.44	$3,237.18

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §124.1 sets out requirements for insurance carriers upon receipt of notice of injury.
2. 28 Texas Administrative Code §124.2 sets out requirements for carrier reporting and notification.
3. 28 Texas Administrative Code §124.3 sets rules for investigating an Injury and giving notice of denial or dispute.
4. 28 Texas Administrative Code §133.200 sets out procedures regarding insurance carrier receipt of medical bills.
5. 28 Texas Administrative Code §133.210 sets out documentation requirements.
6. 28 Texas Administrative Code §133.240 sets out requirements for paying or denying medical bills.
7. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
8. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
9. The insurance carrier did not issue any explanations of benefits to the requestor or submit any EOBs to MFDR for review.

Issues

1. Did the insurance carrier properly return the medical bills to the health care provider?
2. Did the health care provider timely file the medical bill with the insurance carrier?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment for the services in dispute?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The health care provider submitted a medical bill and a request for reconsideration to the insurance carrier. The health insurance carrier's agent (Gallagher Basset) returned both the initial claims submission and the request for reconsideration to the health care provider, without processing them for payment, with the notation that "No claim on record for named patient."

   The respondent argues that "The carrier did not have a claim file for this claimant and this date of injury."

   28 Texas Administrative Code §124.1(a)(3) requires, in pertinent part, that if no Employer's First Report of Injury has been filed, written notice of injury consists of the insurance carrier's earliest receipt of:

   > any other communication regardless of source, which fairly informs the carrier of the name of the injured employee, the identity of the employer, the approximate date of the injury and information which asserts the injury is work related.

   Review of the submitted medical bill and accompanying documentation finds that it meets the requirements of Rule §124.1(a)(3) with regard to fairly informing the carrier of the name of the injured employee, the identity of the employer, the approximate date of the injury and information which asserts the injury is work related. This information therefore constitutes written notice of injury to the insurance carrier.

   Rule §124.1(d) Requires that "The carrier shall immediately create a written record on paper or in an electronic format of the earliest notice of injury as defined in subsection (a) of this section that is not received in writing."

   Rule §124.1(f) further requires that "If a carrier is notified of an injury for which it has not received an Employer's First Report of Injury, from the employer, the carrier shall contact the employer regarding the injury within seven days of notification."

   28 Texas Administrative Code §133.210(e) states:

   > It is the insurance carrier's obligation to furnish its agents with any documentation necessary for the resolution of a medical bill. The Division considers any medical billing information or documentation possessed by one entity to be simultaneously possessed by the other.

   No information was presented by the respondent to support that the insurance carrier met its obligations to investigate and establish a written record of the claim.

   28 Texas Administrative Code §124.2(d) requires that "The carrier shall notify the Commission [now the division] and the claimant of a denial of a claim (Denial) based on non-compensability or lack of coverage in accordance with this section and as otherwise provided by this title.

   Rule §124.2(g)(f) requires that:

   > Notification to the claimant as required by subsections (d) and (e) of this section requires the carrier to use plain language notices with language and content prescribed by the Commission. These notices shall provide a full and complete statement describing the carrier's action and its reason(s) for such action. The statement must contain sufficient claim-specific substantive information to enable the employee/legal beneficiary to understand the carrier's position or action taken on the claim. A generic statement that simply states the carrier's position with phrases such as "employee returned to work," "adjusted for light duty," "liability is in question," "compensability in dispute," "under investigation," or other similar phrases with no further description of the factual basis for the action taken does not satisfy the requirements of this section.

Rule §124.2(g) further requires, in pertinent part:

> when a carrier notifies the Commission [now the division] of a denial as required by subsection (d) of this section, it must provide the Commission a written copy of the notice provided to the claimant under subsection (f) of this section. The notification requirements of this section are not considered completed until the copy of the notice provided to the claimant is received by the Commission.

Whereas 28 Texas Administrative Code §124.3(a) requires that:

> upon receipt of written notice of injury as provided in §124.1 of this title (relating to Notice of Injury) the carrier shall conduct an investigation relating to the compensability of the injury, the carrier's liability for the injury, and the accrual of benefits. If the carrier believes that it is not liable for the injury or that the injury was not compensable, the carrier shall file the notice of denial of a claim (notice of denial) in the form and manner required by §124.2 of this title (relating to Carrier Reporting and Notification Requirements).
> (1) If the carrier does not file a notice of denial by the 15th day after receipt of the written notice of injury, the carrier is liable for any benefits that accrue and shall initiate benefits in accordance with this section.

Furthermore, Rule §124.3(a)(2)(B) requires that:

> The insurance carrier is liable for and shall pay for all medical services, in accordance with the Act and rules, provided prior to the filing of the notice of denial.

Review of the submitted information finds that the respondent has not provided any information regarding a denial of claim based on non-compensability or lack of coverage. Moreover, neither has the carrier provided any documentation of having sent the required plain language notice regarding such a denial to the injured employee.

28 Texas Administrative Code §133.200(a) requires that "Upon receipt of medical bills submitted in accordance with §133.10(a)(1) and (2) . . . an insurance carrier shall evaluate each medical bill for completeness as defined in §133.2"

Per Rule §133.200(a)(1), "Insurance carriers shall not return medical bills that are complete, unless the bill is a duplicate"

Review of the submitted information finds that the insurance carrier returned the bill (as well as the request for reconsideration) to the medical provider without submitting the bill(s) for review of payment, without providing any explanations of benefits, or reasons for reduction or denial of payment, and without investigating the claim in accordance with the requirements of 28 Texas Administrative Code Chapter 124.

On the bill return cover letter, the insurance carrier did not state that the bills were returned as incomplete, but rather indicated their reason as "No claim on record for named patient." This is not an acceptable reason for returning a medical bill under Rule §133.200(a)(1).

Accordingly, the division finds the insurance carrier has improperly returned a complete medical bill (which was not a duplicate) as well as the request for reconsideration and therefore the insurance carrier has failed to meet the requirements of Rule §133.200(a)(1).

Rule § 133.240(a) requires that the insurance carrier shall take final action after conducting bill review "not later than the 45th day after the insurance carrier received a complete medical bill."

Rule §133.240 (e) requires when paying or denying a medical bill, the carrier shall send to the health care provider an "explanation of benefits in accordance with the elements required by . . ." Rules §133.500 and §133.501.

The division finds the insurance carrier failed to take final action within 45 days of receipt of the complete medical bill.

All workers' compensation insurance carriers are expected to fulfill their duty to take final action as required by law and the division's administrative rules. The insurance carrier failed to do so in this case.

For all the above reasons, the division finds that the disputed services are eligible for medical fee dispute and will therefore be reviewed for reimbursement according to applicable division rules and fee guidelines.

2. The respondent further argues that "The carrier denies receiving a timely submitted medical bill from the provider."

   Firstly, the health care provider submitted evidence satisfactory to the division to establish insurance carrier receipt of the medical bills within 95 days of the date of service. The respondent's argument that the medical bill was not timely is without merit.

   Secondly, the insurance carrier returned the bills to the provider without issuing an EOB and without denying the charges for any reasons related to timely filing.

   Rule §133.307(d)(2)(F) requires that "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

   The respondent's position statement raises new denial reasons or defenses that were never issued to the provider as explanations or adjustment reason codes presented on an explanations of benefits. The respondent did not otherwise provide evidence or demonstrate that such denial reasons or defenses were communicated to the health care provider before the filing of the request for MFDR.

   Consequently, the division concludes the respondent has waived the right to raise such additional denial reasons or defenses at MFDR. Newly raised denial reasons or defenses shall not be considered in this review.

3. This dispute regards outpatient hospital facility services with payment subject to 28 Texas Administrative Code §134.403, which requires the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount (including outlier payments) applying the effective Medicare Outpatient Prospective Payment System (OPPS) formula and factors, published annually in the Federal Register, with modifications as set forth in the rule. Medicare OPPS formulas and factors are available from http://www.cms.gov.

   Rule §134.403(f)(1) requires that the sum of the Medicare facility specific amount and any applicable outlier payment be multiplied by 200 percent, unless a facility or surgical implant provider requests separate payment of implantables. Separate reimbursement was not requested for implantables.

4. Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) for billed services based on procedure codes and supporting documentation. The APC determines the payment rate. Hospitals may be paid for more than one APC per encounter. Payment for ancillary items and for services without procedure codes is packaged into the APC payment. The Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates in the OPPS final rules, available from www.cms.gov.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure codes 36415, 80053, 81003, 83690, 85025, G0431, G6040, J2405, J2270, A9579, and Q9957 have payment status indicator N denoting packaged items and services with no separate APC payment; reimbursement for these items is included in the payment for the primary services performed.
   - Procedure code 96374 has status indicator S, denoting a significant OPPS procedure, not subject to multiple-procedure discounting, paid by APC. Per OPPS Addendum A, this is classified under APC 0438, which has a payment rate of $108.24. This amount multiplied by 60% yields an unadjusted labor amount of $64.94, which is multiplied by the facility's annual wage index of 0.9731 yielding an adjusted labor portion of $63.19. The non-labor portion is 40% of the APC rate or $43.30. The sum of the labor and non-labor amounts is $106.49. The service cost does not exceed the fixed-dollar threshold of $2,775. The outlier payment is $0. The total Medicare facility specific amount is $106.49, which is multiplied by 200% for a MAR of $212.98.
   - Procedure code 96375 has status indicator S, denoting a significant OPPS procedure, not subject to multiple-procedure discounting, paid by APC. Per OPPS Addendum A, this is classified under APC 0436, which has a payment rate of $32.58. This amount multiplied by 60% yields an unadjusted labor-related amount of $19.55, multiplied by the facility's annual wage index of 0.9731 yields an adjusted labor portion of $19.02. The non-labor portion is 40% of the APC rate or $13.03. The sum of the labor and non-labor amounts is $32.05. The service cost does not exceed the fixed-dollar threshold of $2,775. The outlier payment is $0. The total Medicare facility specific amount is $32.05, which is multiplied by 200% for a MAR of $64.10.

- Procedure code 99285 is assigned status indicator V denoting a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 0616, which has a payment rate of $492.69. This amount multiplied by 60% yields an unadjusted labor-related amount of $295.61, multiplied by the facility's annual wage index of 0.9731 yields an adjusted labor portion of $287.66. The non-labor portion is 40% of the APC rate or $197.08. The sum of the labor and non-labor amounts is $484.74. The service cost does not exceed the fixed-dollar threshold of $2,775. The outlier payment is $0. The total Medicare facility specific amount is $484.74, which is multiplied by 200% for a MAR of $969.48.
- Procedure code 70553 is assigned status indicator S denoting a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0337, which has a payment rate of $483.08. This amount multiplied by 60% yields an unadjusted labor-related amount of $289.85, multiplied by the facility's annual wage index of 0.9731 yields an adjusted labor portion of $282.0. The non-labor portion is 40% of the APC rate or $193.23. The sum of the labor and non-labor amounts is $475.28. The service cost does not exceed the fixed-dollar threshold of $2,775. The outlier payment is $0. The total Medicare facility specific amount is $475.28, which is multiplied by 200% for a MAR of $950.56.
- Procedure codes 70450, 70496, and 70498 have status indicator Q3 denoting conditionally packaged codes paid through a composite APC. Services assigned to a composite APC are major components of a single episode of care; the hospital receives one payment under a composite APC for multiple separate major services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. These services are assigned to composite APC 8006, for computed tomography (CT) services including contrast. If a “without contrast” CT procedure is performed on the same date of service as a “with contrast” CT, APC 8006 is assigned rather than APC 8005. If a composite includes multiple line items, the charges for those combined services are summed to one line. To determine outliers, a single cost for the composite is estimated from the summarized charges. Total packaged cost is allocated to the composite line item in proportion to other separately paid services on the bill. This line is assigned status indicator S denoting a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 8006, which has a payment rate of $528.56. This amount multiplied by 60% yields an unadjusted labor-related amount of $317.14, which is multiplied by the facility's annual wage index of 0.9731 yields an adjusted labor portion of $308.61. The non-labor portion is 40% of the APC rate or $211.42. The sum of the labor and non-labor amounts is $520.03. The service cost does not exceed the fixed-dollar threshold of $2,775. The outlier payment is $0. The total Medicare facility specific amount is $520.03, which is multiplied by 200% for a MAR of $1,040.06.

5. The total allowable reimbursement for the services in dispute is $3,237.18. The insurance carrier paid $0.00. The amount due to the requestor is $3,237.18. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $3,237.18.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $3,237.18, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	August 11, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.